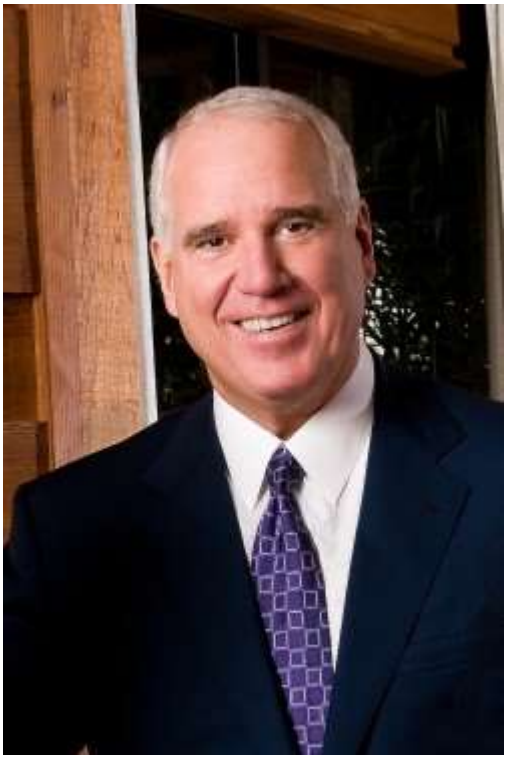
Michael J. Bidart



As a preeminent consumer attorney, Michael J. Bidart has made a major impact on our healthcare system. Mr. Bidart is the Managing Partner for the firm, and he leads the firm's HMO Litigation and Property/Casualty Departments.

Since bringing his expertise to the firm in 1986, Mr. Bidart has developed the firm's alth insurance practice by successfully prosecuting bad faith disputes against insurers and HMOs.

His inexhaustible efforts were showcased in 1999 with a landmark $120.5 million verdict against Aetna over its refusal to pay for care recommended by the health plan's own physicians (*Goodrich v. Aetna*). It is the largest jury verdict ever rendered against an HMO nationally. Recently, he was victorious on a jury trial on behalf of a young woman who lost her leg due to Kaiser Permanente's negligent care. The jury awarded the woman $28.2 million.

Mr. Bidart's dedication and expertise are also exemplified by many earlier landmark decisions. In *State Farm v. Superior Court* (1996) he helped establish definitively that "unfair business practice" statutory liability applies to insurance companies in California. For victims of the 1994 Northridge earthquake he won more than $300 million. He was a key player in the California Public Employees Retirement System's decision to expand its health care benefits for women with breast cancer, and he led the firm's effort to ensure that prostate cancer patients statewide receive proton beam therapy as a covered benefit under their insurance policies.

Mr. Bidart has been named a Super Lawyer by *Law & Politics Magazine* every year since 2004 and has been a Super Lawyer Top 100 Attorney every year since 2004 and Top 10 in 2018. He has been profiled in the *National Law Journal*, *The American Lawyer* and *California Lawyer Magazine*, which have recognized him as one of California's most influential lawyers. The *Wall Street Journal* has also noted that Mr. Bidart's success in healthcare litigation helped to reignite the debate in Congress over whether patients should have the right to sue their health plans.

A well-known lecturer and keynote speaker on HMO litigation and bad faith insurance practices, Mr. Bidart has been a featured speaker for the Association of Trial Lawyers of America, Consumer Attorneys of California, American Conference Institute, The Rutter Group, the California Judges Association and many others.

Mr. Bidart has served on the Board of Governors of Consumer Attorneys of California and Consumer Attorneys Association of Los Angeles, on the Board of Regents of Loyola Marymount University and as chairman of the Board of Visitors for the University of La Verne Law School.

Mr. Bidart graduated from California State Polytechnic University, Pomona (B.S., 1971) and Pepperdine University School of Law (J.D., 1974).

AREAS OF PRACTICE

- HMO/Healthcare Litigation
- Property/Casualty
- Duty to Defend
- Excess Verdict Recovery
- (100% of Practice Devoted to Litigation)

EDUCATION

- Pepperdine University School of Law, Malibu, California, 1974; J.D.
- California State Polytechnic University, Pomona, California, 1971; B.S

HONORS AND AWARDS

- Consumer Attorneys Association of Los Angeles (CAALA) Trial Lawyer of the Year, 2015
- CAL ABOTA Trial Lawyer of the Year, 2011
- *Los Angeles Daily Journal* Top Verdict Honoree, 2016
- *Los Angeles Daily Journal* Top 25 California Plaintiff Attorney, 2015, 2016
- Southern California Super Lawyers Top 100, 2004-2017
- Southern California Super Lawyers Top 10, 2018
- *Law & Politics Magazine*, Super Lawyer, 2004-2017
- *Who's Who Legal:*Insurance & Reinsurance, 2016
- Best Lawyers' Inland Empire Insurance Law "Lawyer of the Year", 2014, 2017
- *Law360* Insurance Law MVP, 2014-2015
- Association of Southern California Defense Counsel (ASCDC), Civil Advocate Award, 2008
- California's 100 Most Influential Lawyers, *California Lawyer Magazine*

PROFESSIONAL ASSOCIATIONS AND MEMBERSHIPS

- American Board of Trial Advocates, Fellow
- American College of Trial Lawyers, Fellow
- International Academy of Trial Lawyers, Fellow
- Consumer Attorneys of California, Past Member of the Board of Governors
- American Association for Justice
- Consumer Attorneys Association of Los Angeles, Past Member of the Board of Governors
- Loyola Marymount University; Board of Regents (Emeritus)
- American Bar Association
- Los Angeles County Bar Association
- San Bernardino County Bar Association

BAR ADMISSIONS

Federal

- United States Supreme Court
- S. Court of Appeals
- S. District Court Central District of California
- S. District Court Northern District of California
- S. District Court Eastern District of California
- S. District Court Southern District of California

State

- California Supreme Court

CLASSES/SEMINARS TAUGHT

- Lecturer, HMO Litigation and Bad Faith Insurance Practices
- Keynote Speaker, HMO Litigation and Bad Faith Insurance Practices
- Featured Speaker, Association of Trial Lawyers of America
- Featured Speaker, Consumer Attorneys of California
- Featured Speaker, American Conference Institute
- Featured Speaker, The Rutter Group
- Featured Speaker, California Judges Association
- Healthcare Litigation, *Wall St. Journal*

OFFICIALLY REPORTED CASES (PARTIAL LISTING)

Dozens of published opinions are the result of Mr. Bidart's work on behalf of insurance consumers; he has made his mark, helping to establish protections for insureds throughout California. Below are some of his more prominent published decisions.

- *Berman v. Health Net,*80 Cal.App.4th 1359, 96 Cal.Rptr.2d 295, 2000 WL 681029, 00 Cal. Daily Op. Serv. 4164, 2000 Daily Journal D.A.R. 5573, Cal.App. 2 Dist., May 26, 2000 (No. B125182) – An employee agreed, by enrolling in a medical insurance plan, to submit any dispute to arbitration. The insured and his wife, in the course of her treatment under the medical plan, brought an action against the medical insurer for breach of the duty of good faith and fair dealing, breach of contract, breach of fiduciary duty, negligent and intentional infliction of emotional distress, and for injunctive relief for unfair competition. Counsel for the parties stipulated that defendant's challenges to the pleadings would not be deemed a waiver of its right to seek an order compelling arbitration. The parties then engaged in extensive discovery. The trial court denied defendants' subsequent motion to compel arbitration, finding that defendant waived the right to compel arbitration by engaging in substantial discovery, and the trial court also denied defendant's motion for reconsideration. The Court of Appeal affirmed the judgment denying defendant's motion to compel arbitration. The court held that defendant waived its right to compel arbitration under the parties' agreement. The trial court properly drew an inference that defendant sought and obtained information not available in arbitration during discovery, thus causing prejudice to plaintiff, and that inference was supported by the record.

- *Burks v. Kaiser Foundation Health Plan, Inc*., 160 Cal.App.4th 1021, 73 Cal.Rptr.3d 257, 2008 WL 590872, 08 Cal. Daily Op. Serv. 2717, 2008 Daily Journal D.A.R. 3321, Cal.App. 3 Dist., March 05, 2008 (No. C054374.) – A health plan subscriber brought action against a health plan. The plan petitioned to compel arbitration. The Sacramento Super Court denied petition, after which The Court of Appeal held that the arbitration notice on the plan enrollment form was not "prominently displayed," and the arbitration notice did not substantially comply with California Health & Safety Code § 1361.2.
- *Goodrich v. Aetna, Inc.*, Not Reported in Cal.Rptr.2d , 1999 WL 181418, Not Officially Published, Cal.App.Super., March 29, 1999 (No. RCV 20499.) – Aetna Insurance was found guilty by a jury in California of letting David Goodrich die a painful death from cancer resulting in Aetna's denial of the timely delivery of essential care services. Despite Aetna's claim to the contrary, the Aetna health care policy was found to not contain any exclusions or limitations to the health care treatments recommended by the Aetna in-plan cancer doctor's (oncologist). Aetna claims processors used a "Terminal Illness Policy" procedures and guidelines process to deny treatment to Mr. Goodrich even though the Mr. Goodrich's insurance policy did not contain any exclusions for experimental or investigational procedures. The jury awarded damages totaling $120,546,363.40. On appeal, the California Appeals Court stated Mr. Goodrich was "exemplary human being in every aspect of his life" and found that Aetna's parent company, Aetna Services, Inc. should also be liable and that the verdict, the largest against an HMO in history, was not excessive.
- *Groom v. Health Net*, 82 Cal.App.4th 1189, 98 Cal.Rptr.2d 836, 2000 WL 1123604, 00 Cal. Daily Op. Serv. 6693, 2000 Daily Journal D.A.R. 8797, Cal.App. 2 Dist., August 09, 2000 (No. B131271.) – A member of a health plan administered by an HMO brought an action against the organization, alleging that plaintiff suffered a stroke after the HMO refused to timely provide appropriate examinations and medication. The defendant moved to compel arbitration of the dispute pursuant to the arbitration clause contained in the health plan, but the trial court denied defendant's petition to compel arbitration. The Court of Appeal reversed the order denying defendant's petition to compel arbitration and issued directions to enter an order compelling arbitration. The court held that the trial court erred in finding that defendant waived its right to compel arbitration, notwithstanding defendant's demurrers to plaintiff's complaint, since there had been no litigation on the merits, and plaintiff was unable to demonstrate prejudice.
- *Imbler v. PacifiCare of Cal., Inc.*, 103 Cal.App.4th 567, 126 Cal. Rptr.2d 715, 2002 WL 31475007, 02 Cal. Daily Op. Serv. 11,009, 2002 Daily Journal D.A.R. 12,735, Cal.App. 4 Dist., November 06, 2002 (No. E030820) – An insured brought an action, alleging various causes, against his HMO to recover for defendant's failure to pay for his cancer treatment. The trial court denied defendant's petition to compel arbitration made pursuant to an arbitration provision. The Court of Appeal affirmed, holding that the trial court properly denied defendant's petition to compel arbitration, since defendant's arbitration provision failed to meet the requirement of the law, that an arbitration provision in a health care service plan be prominently displayed. The court further held that the health code is not preempted by the Federal Arbitration Act.
- *Kaiser Foundation Health Plan v. Superior Court*(*Rahm*) 203 Ca.App.4th 696 (2012) – Holding: That Insureds brought action against a health care service plan for breach of the implied covenant of good faith and fair dealing and intentional infliction of emotional distress, and sought punitive damages. Kaiser moved to strike the punitive damages allegations. The Superior Court judge denied the motion to strike. Kaiser then petitioned for writ of mandate and the Court of Appeal summarily denied the petition. Kaiser then petitioned for review and the Supreme Court granted review and remanded with directions. The court held that the statute requiring leave of court for punitive damages allegations does not apply to claims against health care service plans, and the insureds' punitive damages allegations did not require leave of court.

- *Kotler v. PacifiCare of California*, 126 Cal.App.4th 950, 24 Cal.Rptr3d 447, 2005 WL 318681, 05 Cal. Daily Op. Serv. 1310, 2005 Daily Journal D.A.R. 1713, Cal.App. 2 Dist., February 10, 2005(No. B171654.) – An insured patient who encountered delays in treatment brought a breach of contract and breach of implied covenant of good faith and fair dealing against his health care service plan and its parent corporation. The Los Angeles Superior Court granted defendants summary judgment and then patient appealed. The Court of Appeal held that the patient's treatment with out-of-network specialist was not "emergency medical condition" reimbursable under plan agreement, but the triable issue of fact remained whether six-week wait for appointment constituted breach of plan's implied-in-law obligation.
- *Medeiros v. Superior Court*, 146 Cal.App.4th 1008, 53 Cal.Rptr.3d 307, 2007 WL 93170, 07 Cal. Daily Op. Serv. 609, 2007 Daily Journal D.A.R. 745, Cal.App. 2 Dist., January 16, 2007 (No. B193042.) – Employees filed lawsuit against their health insurer for breach of contract and bad faith, and health insurer filed motion to compel arbitration. The Superior Court granted a motion to compel arbitration, and employees petitioned for a writ of mandate. The Court of Appeal held that arbitration provisions in employer's health benefits election agreement and evidence of coverage form were unenforceable based on failure to comply with statutory disclosure requirements.
- *Minkler v. Safeco*, 49 Cal.4th 315 (2010) – In responding to a certified question from the Ninth Circuit The assignee of insured's rights under liability policy brought action against Safeco for breach of contract and breach of the covenant of good faith and fair dealing. Insurer removed the case to the United States District Court for the Central District of California and the District Court granted Safeco's motion to dismiss. The assignee appealed to the United States Court of Appeals for the Ninth Circuit which certified a question to the California Supreme Court. The Court held that exclusion barring coverage for intentional acts did not bar coverage for negligently failing to prevent another insured's intentional acts, where the insurance applied "separately to each insured."
- *Mintz v. Blue Cross*, 172 Cal.App.4th 1594 (2009) – An insured under a health insurance plan brought an action against the administrator of the plan, alleging claims for interference with contractual relations, intentional infliction of emotional distress, and negligence, arising from administrator's denial of coverage for cancer treatment as investigational, and failure to inform insured of his right to seek independent review of the denial. The Los Angeles Superior Court sustained the administrator's demurrer, and insured appealed. The Court of Appeal held that the administrator could not be liable for intentional interference with contractual relations; administrator's actions were not extreme and outrageous conduct, as required to state a claim for intentional infliction of emotional distress; but the administrator had a duty, as element of negligence, to exercise due care to protect insured from physical injury in making benefit determinations under plan.
- *Notrica v. State Compensation Ins. Fund*(aka *State Compensation Ins. Fund*), 70 Cal.App.4th 911, 83 Cal.Rptr.2d 89, 1999 WL 141814, 64 Cal. Comp. Cases 378, 99 Cal. Daily Op. Serv. 1933, 1999 Daily Journal D.A.R. 2503, Cal. App. 2 Dist., March 17, 1999 (No. B097529) – An employer sued the State Compensation Insurance Fund to recover damages for tortuous breach of good faith and fair dealing and for unfair business practices, based on allegations that defendant's failure to estimate reasonable claim reserve levels resulted in plaintiff's paying higher premiums and receiving lower dividends. The trial court entered judgment for plaintiff on the jury's verdict awarding $478,606 in compensatory damages for breach of the duty of good faith and fair dealing, and $20 million in punitive damages under Civ. Code, § 3294. The court also issued an injunction requiring defendant to delete the term "maximum probable potential" from its claims estimating manual and to return to a previous standard. The Court of Appeal held: the trial court did not err in permitting tort recovery for breach of the implied covenant of good faith and fair dealing based solely on the fact that defendant's practices affected plaintiff's future premiums; the substantial evidence supported the trial court's findings of bad faith; that the jury properly awarded plaintiff compensatory damages. In addition, the court held

that the trial court properly granted an injunction requiring defendant to delete the term "maximum probable potential" from its claims estimating manual and to return to a previous standard, and further enjoining defendant from other unfair business practices.

- *Oakland-Alameda County Coliseum, Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 480 F.Supp.2d 1182, 2007 WL 949687, N.D.Cal., March 21, 2007 (No. C06-2328 MHP.) – The insured brought a state court suit against directors and officers (D&O) liability insurer and eight excess insurance carriers, alleging breach of contract, breach of the implied covenant of good faith and fair dealing, and seeking declaratory relief. The action was removed and the insurers moved for summary judgment. The District Court had several holdings: notice section of D & O policy did not dispense with timing requirement for notices mailed on last day of coverage; the timing provision applied to expiration date; the insurer did not waive timeliness defense to notice of claim through nine-year delay in asserting defense; the insurer was not stopped from asserting timeliness defense; the insured's reporting of litigant's demands and threats constituted making a claim under policy; one excess policy was a claims-made policy rather than claims-made-and-reported policy under which showing of prejudice was not required; and the coverage for negligent misrepresentation was not barred by Insurance Code.
- *Smith v. PacifiCare Behavioral Health of California, Inc.*, 93 Cal.App.4th 139, 113 Cal.Rptr.2d 140, 2001 WL 1298977, 01 Cal. Daily Op. Serv. 9230, 2001 Daily Journal D.A.R. 11,463, Cal.App. 2 Dist., October 25, 2001 (Nos. B142321, B145004.) The court held, for the first time, that California health care service plans (HMO's) were engaged in the business of insurance, finding that "HMOs function the same way as a traditional health insurer" and "are in the business of insurance." Smith also held that health insurers and HMOs in California were required to comply with California statutes that regulated the use of arbitration clauses in health-insurance contracts–those that failed to comply with the requirements would not be enforceable.
- *State Farm Fire & Casualty Co. v. Superior Court*, 45 Cal.App.4th 1093, 53 Cal.Rptr.2d 229, 1996 WL 273490, 96 Cal. Daily Op. Serv. 3713, 96 Daily Journal D.A.R. 5973, Cal.App. 2 Dist., May 23, 1996 (No. B096075.) (Allegro) The insureds brought suit against homeowners' and earthquake insurer under Unfair Competition Act of California Business and Professions Code §17200. The Los Angeles Superior Court overruled demurrer to the complaint, and the insurer sought writ of mandate. The Court of Appeal held that: an insurer's conduct constituting a breach of the implied covenant of good faith may also constitute an unfair business practice under section 17200 and a claim for injunctive or restitutive relief under the UCA can be based on any fraudulent or unlawful or unfair business activity.
- *Zolezzi v. PacifiCare of California*, 105 CalApp.4th 573, 129 Cal.Rptr.2d 526, 2003 WL 139718, 03 Cal. Daily Op. Serv. 626, 2003 Daily Journal D.A.R. 825, Cal.App. 4 Dist., January 21, 2003 (No. D039779) – Through her guardian, a patient brought an action against a Medicare Choice health care plan provider, alleging breach of the duty of good faith and fair dealing, intentional infliction of emotional distress, and other claims, arising from defendant's refusal to authorize surgery for a fractured bone. The trial court denied defendant's petition to compel arbitration, concluding that the federal Medicare Act did not preempt application the law, and defendant's noncompliance with the arbitration disclosure requirements. The Court of Appeal affirmed this and held that the trial court properly denied defendant's petition to compel arbitration, since the federal Medicare Act did not preempt application of the law, and defendant's noncompliance with the arbitration disclosure requirements precluded enforcement of the contractual arbitration provision. The court further held that the newly added preemption provision did not preempt application since the amendment does not apply retroactively.